SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 201304283, A Medical Practice in the Greater Glasgow and Clyde NHS Board area
Sector: Health
Subject: GP and GP Practices; complaints handling

Summary
Mr A had concerns about the care and treatment he received from his medical practice in diagnosing his kidney condition. An advice worker (Ms C) complained to the practice on his behalf in April 2013. When she had not received a response to her complaint, despite chasing a response and resubmitting her complaint, she complained to my office. Ms C noted that the only contact she had with the practice was a reply from them asking her to pay £50 to release Mr A's medical records, which was not what she had asked for. She was also concerned that the practice was operating outwith the NHS complaints procedure, as her complaint should have been acknowledged within three days and responded to within 20 working days. My complaint reviewer considered the evidence available, upheld Ms C's complaint and made recommendations to the practice, which were to issue a response to Ms C's original complaint, apologise to Mr A and review their complaints handling procedure. We published our decision on this case in March 2014.

There then followed several attempts from my office to ensure that the practice had complied with our recommendations. The correspondence we received from the doctor at the practice noted that the practice had no idea what their mistake was or what they were to apologise for. Eventually, after making several attempts to correspond with the practice, I wrote to the chief executive of the board to make them aware of the matter. The chief executive noted that many of the statements made by the practice to my office during our investigation were inaccurate. In particular, the chief executive confirmed that the mail system within the building in which the practice was located was not dysfunctional (the practice had said that the mail system had led to them not receiving Ms C's initial complaint).

I took independent advice from one of my clinical advisers who is a GP. He noted that whilst Ms C presented a credible history, the practice appeared to contradict themselves and were less credible with the explanations and information they had provided to us. My adviser commented that the practice

did not appear to have correct and proper systems in place to ensure the safe running of the practice. In addition, he said the chaotic way in which the practice dealt with Ms C's complaint including treating it as a request for copies of medical records and requesting a payment for £50 was worrying. My adviser highlighted a number of sections of the General Medical Council (GMC)'s Good Medical Practice guidance, and noted where the practice appear to have failed to demonstrate their compliance with this guidance, including their failure to operate a credible complaints system.

The advice I have received, and accepted, is that the practice had deliberately complicated the issues around Mr A's complaint with the aim of not answering it, which was compounded by the poor systems they had in place for handling complaints. The practice's failure to engage with the board to allow mediation and assistance to improve their situation led to the injustice of Mr A not having his complaint answered.

Finally, my adviser commented that the actions, and lack of action, taken by the practice were serious enough to threaten the reputation of the medical profession because they had repeatedly failed in the duties expected of them by the GMC. The evidence available indicates that they failed to handle Ms C's complaint appropriately in line with the NHS 'Can I Help You?' guidance. In addition, I have extreme concerns about the practice's resistance to accept that they failed to handle the complaint properly. Their refusal to comply with my recommendations has resulted in my office having to issue this report when the complaint should have been finalised following the decision issued by my complaints reviewer over a year ago. In light of my serious concerns, I have not only made further recommendations to the practice, but also recommended that the board consider the contract held with the practice, and consider whether to refer the practice to the GMC.

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) acknowledge acceptance of Mr A's complaint and answer it appropriately within 20 working days;	23 September 2015
(ii) apologise to Mr A for failing to deal with his complaint appropriately in line with *Can I help you?*; and	23 September 2015
(iii) provide the SPSO with a copy of its complaint	23 September 2015

handling procedure to demonstrate compliance with *Can I help you?.*

The Ombudsman recommends that the Board:	*Completion date*
(i) consider referring the Practice to the GMC; and	28 October 2015
(ii) consider its position in relation to the contract held with the Practice.	28 October 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Main Investigation Report

Introduction

1. Mr A was diagnosed with Tubulointerstitial Nephritis which can be a cause of kidney failure. After becoming aware of his condition, Mr A had concerns about the care and treatment he received from his medical practice (the Practice). The Practice is sited within a health centre (the Centre) consisting of 25 GP services. Mr A approached a Citizens Advice Bureau for support, and Ms C submitted the complaint to the Practice on his behalf in April 2013. Ms C made several enquiries with the Practice to chase a response to the complaint, and she also resubmitted the complaint, but she did not receive a response and because of that, Ms C submitted a complaint to my office.

2. The complaint from Ms C which I have investigated is that the Practice failed to adequately respond to the complaint.

Investigation

3. As part of our investigation, we contacted the Practice and we also considered the Scottish Government's *Can I help you?* document which provides good practice guidance for handling and learning from feedback, concerns and complaints for health service providers. In addition, I took independent advice from one of my clinical advisers (the Adviser) who is a general practitioner.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Practice were given an opportunity to comment on a draft of this report. A copy was also sent to Greater Glasgow and Clyde NHS Board (the Board).

Complaint: The Practice failed to adequately respond to the complaint

5. In April 2013, Ms C submitted a complaint addressed to the practice manager of the Practice on behalf of Mr A about the care and treatment he had received. Ms C did not receive an acknowledgement or a response to the complaint so she submitted reminders to the Centre in June and July 2013. An unsigned letter was sent to Ms C which appeared to have been issued by an administrator in the Centre advising that her correspondence was being returned because it needed to be addressed to the intended recipient.

6. Ms C noted that it was normal practice to send a complaint addressed to the practice manager who was usually the primary contact in the complaints procedure but she sent a further letter addressed to the doctor of the Practice in August 2013. She noted that she had submitted a complaint on behalf of Mr A and following a telephone enquiry to the receptionist of the Practice, she was advised that the complaint had been received and was still being considered. Following this, Ms C received a compliment slip advising that the documents she had requested in relation to Mr A were ready and that a payment of £50 should be forwarded to the Practice.

7. In September 2013, Ms C sent a further letter to the Practice. She referred to a recent telephone call made by her to the Practice in which she called to confirm that she had not requested access to Mr A's documents and instead, she was looking for a response to the complaint submitted to the Practice in April 2013. Ms C referred to the arrangements laid out for the handling of and responding to patient feedback in the Patient Rights (Scotland) Act 2011 and asked the Practice to respond to Mr A's complaint and to provide a copy of their own complaints procedure and policies.

8. Ms C wrote to the Practice again in October 2013 because she still had not received their response to the complaint. She asked the Practice to respond within 14 days and confirmed that if she did not receive a response, she would forward Mr A's complaint to the SPSO.

9. Because she did not receive a response from the Practice, Ms C referred Mr A's complaint to my office. She said she wanted us to investigate the Practice's handling of the complaint and to ask them to respond to it.

10. My complaints reviewer contacted the Practice and spoke with the practice manager who advised that a response was issued to Ms C's complaint in October 2013. The practice manager also advised my complaints reviewer that the Practice only became aware of the complaint in August 2013.

11. The practice manager forwarded two letters to my complaints reviewer that she said were sent to Ms C in response to the complaint. The first letter advised Ms C that her correspondence did not reach the Practice until 14 August 2013 and it disputed her claims of having called the Practice on two occasions. It also asked Ms C to confirm the nature of Mr A's complaint and

indicated that the Practice would need to see him before submitting their response.

12. The second letter was dated in October 2013. It noted that Mr A had attended the Practice to discuss matters with the doctor. In addition, it advised that Mr A no longer wanted to pursue the complaint and that he wanted Ms C to stop sending letters to the Practice.

13. The practice manager advised my complaints reviewer that there were problems with the incoming mail system at the Centre. In particular, she explained that mail for all 25 GP services was received and sorted within the same area. The Practice said they moved into the Centre in August 2012 and since then, they had submitted several complaints to the medical director for Glasgow City Community Health Partnership (CHP) about the mail system.

14. My complaints reviewer shared both of the letters provided to her by the Practice with Ms C who advised that the letters had not been received by her. In addition, Ms C confirmed the only active contact she had with the Practice was the fax in August 2013 (referred to in paragraph 6) in which she received the compliment slip requesting a fee of £50 and a telephone call from the doctor. Ms C confirmed that she made two telephone calls to the Practice in July 2013 and it was in the second call that she had been advised the complaint was being considered.

15. Ms C also raised concerns about the alleged discussion that was to have taken place with Mr A and the doctor. She said she had no way of knowing whether a full explanation was provided to the issue raised or whether any learning outcomes were identified. In addition, Ms C said she was unable to determine whether the complaint was properly investigated. Ms C also confirmed that her initial correspondence with the Practice, and her conversation with the doctor, had confirmed her preferred method of communication was in writing.

16. Ms C also disputed the statement from the Practice that Mr A no longer wished to pursue the complaint. Ms C said she discussed the matter with Mr A in August and December 2013. She said that when Mr A met with her in December 2013, he advised that the doctor told him not to continue with the complaint. Ms C said Mr A confirmed that he wanted to pursue the complaint further and requested that the matter be referred to the SPSO. Ms C pointed

out that Mr A signed the SPSO complaint form which proved that he wanted to continue with the complaint.

17. Ms C was concerned that the Practice were still to provide a response to the complaint, namely that the doctor failed to make a diagnosis despite the regular presentation of certain symptoms. Ms C said there were further concerns that the Practice appeared to be operating outwith the NHS complaint procedure and had failed to provide a copy of their own complaints procedure.

18. The Patient Rights (Scotland) Act 2011, together with supporting legislation, introduced the right to give feedback, make comments, raise concerns and to make complaints about NHS services and it also placed a responsibility on the NHS to encourage, monitor, take action and share learning from the views they receive. In support of that, the Scottish Government introduced *Can I help you?* which provides guidance to relevant NHS bodies and their health service providers (which include Primary Care Service Providers) in handling feedback, comments, concerns and complaints.

19. *Can I help you?* outlines what should happen when a complaint is received by an NHS provider. In particular, it confirms that a complaint should be acknowledged within three working days and investigated with a full response provided within 20 working days. If the NHS provider is unable to meet the timescale for response, they should provide a written explanation for the delay and an update on the progress and when they expect to be able to reply. In addition, the NHS provider should advise a complainant of their right to seek a review from SPSO if they do not accept the reasons for the delay.

20. Following my complaint reviewer's consideration of the evidence available, she upheld Ms C's complaint and advised the Practice of the outcome in a decision letter.

21. In support of her decision, my complaints reviewer noted that the Practice said they did not receive notification of Ms C's complaint until August 2013. However, Ms C said she telephoned the Practice in July 2013 and was advised that her correspondence had been received but was still being considered. My complaints reviewer accepted that there were two differing versions of what had happened and without further supporting evidence being available, she was unable to prove whether Ms C's correspondence was received by the Practice before August 2013. However, my complaints reviewer concluded that, if we

accepted that the Practice may have only received Ms C's correspondence in August 2013, *Can I help you?* confirmed that an NHS provider was required to respond to a complaint within 20 working days (four weeks) of receiving it. The evidence presented by the Practice confirmed that they did not write to Ms C with the outcome of their investigation - that Mr A apparently did not want to pursue the complaint - until October 2013, ten weeks after receiving the complaint which is significantly outwith the relevant timescale.

22. Further, having reviewed the Practice's letter from October 2013, which they said was their response to Ms C's complaint, my complaints reviewer concluded that it did not address the issues raised in the complaint appropriately.

23. In light of our findings, my complaints reviewer recommended that the Practice:

- provide a fuller response to the issues Ms C raised in her letter of complaint from April 2013;
- apologise for failing to deal with Ms C's complaint appropriately; and
- review their complaints handling procedure to ensure it complied with the requirements of the *Can I help you?* guidance.

24. Following that, the Practice asked for my complaint reviewer's decision to be reviewed. They said they disagreed with our recommendations because they failed to recognise the efforts made by the Practice in trying to resolve the complaint. In line with our process, the Practice's letter was recorded as a request for a review of our decision and was passed to me for consideration.

25. I wrote to the Practice to confirm that I was satisfied my complaint reviewer's investigation of the matter was thorough and robust, and that the appropriate decision was reached. I asked the Practice to notify my complaints reviewer of the steps they had taken to fulfil the recommendations made.

26. My complaints reviewer did not receive any feedback from the Practice about the steps taken to complete our recommendations so she emailed the practice manager for an update but received no response.

27. My complaints reviewer then received a letter from the doctor asking for an update on their request for a review of our decision. She called the Practice

and obtained an NHS email address from the receptionist so she could forward a copy of the my decision on the review to the doctor.

28. No further communication was received from the Practice so I emailed the practice manager and outlined my concerns. In particular, I noted that the Practice had specifically asked my office to correspond by email given the problems they said they were having with incoming mail. In addition, I asked the Practice to confirm that my recommendations had been accepted and complied with. I advised the Practice that if I did not receive a response, I would contact the chief executive of the Board (the Chief Executive) about the matter. I also confirmed that I was authorised to submit a special report to the Scottish Parliament.

29. The Practice did not acknowledge my email so my complaints reviewer called them to find out whether it had been received. When my complaints reviewer announced that she was calling from my office, the call handler informed her that she had called the wrong number. My complaints reviewer asked whether she had called the Practice to which she was advised that she had. My complaints reviewer advised that she had called the correct number and asked to speak with the practice manager or doctor. After some hesitation from the call handler, my complaints reviewer was advised that both were unavailable but a response to my email had been issued.

30. In the response, the doctor continued to raise concerns about our decision on the complaint. He said he was concerned that their award winning centre was being accused despite the clarity provided on their position. In addition, the doctor said he could not see how the Practice failed to comply with the NHS complaints procedure. He said Ms C had confused staff because they thought she had been requesting copies of Mr A's medical records. The doctor noted that the Practice had no idea what their mistake was or what they were to apologise for and again raised concerns about the mail system within the Centre.

31. My complaints reviewer emailed the Practice to advise them that I would be writing to the Chief Executive to make him aware of our concerns about the Practice's complaints handling and response to the outcome of our investigation into the complaint brought to us by Ms C.

32. The Practice replied to my complaints reviewer and asked her to stop sending unnecessary emails to their staff regarding the matter when the doctor had asked the SPSO to deal with him directly.

33. In response to my letter, the Chief Executive noted that many of the statements made by the Practice to my office were inaccurate. In particular, the Chief Executive confirmed that the mail system within the Centre was not dysfunctional. He advised that a senior member of staff visited the site to review how the system operated and reported that mail was delivered to a central room and the arrangement was that practices within the Centre sort their mail to individual practices using standards mail sorting frames. The Board advised that mail for community services was sorted by Health Centre staff and any that could not be identified was opened to identify the intended recipient and redirected appropriately. The Board explained that if it was not possible to identify the intended recipient, the mail was returned with a standard letter – the same letter sent to Ms C in July 2013 outlined at paragraph 8 of this report. The Board said the letter sent to Ms C was a copy of the template letter used and had been issued to practices within the Centre for information. The Board also advised that at the time of the staff member's visit, the mail had just arrived and was being sorted and it was noted that mail for the Practice delivered the previous week had still not been collected. The Chief Executive confirmed that the practices within the Centre willingly participated in the arrangements described and the Board had no record of any complaints being made about the system, other than those from the Practice. The Chief Executive advised that many of the Glasgow CHP staff had devoted considerable time and effort to seeking to engage with the Practice to secure improvement of their systems. The Chief Executive comments that the arrangements in place continued to be chaotic and that the problems experienced by my office in dealing with the Practice were no different than the on-going problems the Board experienced.

34. I received a further letter from the doctor at the Practice in which he repeated the request that my complaints reviewer should not send unnecessary emails to their staff. The doctor also asked that I provide further information to help him understand 'the dragging on of this complaint despite all the effort to co-operate' with my office. In addition, the doctor said he wanted to reassure me that his staff were fully aware, trained and empowered to handle feedback, comments and concerns. He said the Practice's complaints procedure worked effectively and efficiently and staff saw complaints as an opportunity to improve and deliver high quality service. However, the doctor concluded that, in this

case, he failed to see the value of an apology before understanding what they had done wrong to allow their staff to learn from it.

35. The Adviser noted that whilst Ms C presented a credible history the Practice appeared to contradict themselves and were less credible with the explanations and information they provided. The Adviser commented that the Practice did not appear to have correct and proper systems in place to ensure the safe running of the Practice. In addition, he said the chaotic way in which the Practice dealt with Ms C's complaint including treating it as a request for copies of medical records and requesting a payment for £50 was worrying.

36. The Adviser noted that by insisting on a meeting with Mr A before responding to the complaint was worrying. He said he was left wondering whether the Practice were looking to coerce Mr A into withdrawing his complaint.

37. The Adviser commented that the Practice did not appear to operate a credible complaints system and even if they did, lack of safe working practices within the Practice would not allow such a system to work. For example, he noted the Board's comments that the Practice did not collect their mail in accordance with the system agreed by other practices housed in the Centre. The adviser noted that it appeared to have been this same service failure that led to Mr A not having had his initial complaint considered or answered by the Practice because the Practice denied receiving it.

38. The Adviser referred to the following sections from the GMC's Good Medical Practice guidance. He considered they were relevant in this case because, in his view, the Practice failed to demonstrate compliance with them. In particular, he noted the following:

> '7. you must be competent in all aspects of your work, including management, research and teaching'

39. The evidence available suggests the Practice has not shown that they are capable of operating a competent complaints system.

> '10. You should be willing to find and take part in structure support opportunities offered by your employer or contracting body (for example, mentoring). You should do this when you join an organisation and whenever your role changes significantly throughout your career.

11. You must be familiar with guidelines and developments that affect your work.

12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.

13. You must take steps to monitor and improve the quality of your work.'

40. From the information supplied by both the Practice and the Board there is no evidence of the Practice showing willingness to take part in mentoring to improve their service. They do not show familiarity with complaints guidelines and they do not appear to have kept up to date with how to manage complaints. No evidence has been provided by the Practice to demonstrate steps taken to improve the quality of their work in this area.

'22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

a. taking part in regular reviews and audits of your own work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary

b. regularly reflecting on your standards of practice and the care you provide

c. reviewing patient feedback where it is available.

23. To help keep patients safe you must:

a. contribute to confidential inquiries

b. contribute to adverse event recognition'

41. The Practice have effectively refused to review patient feedback which in this case was in the form of a complaint. They have refused to contribute to this confidential enquiry and to contribute to what may have been an adverse event. This again demonstrates a lack of willingness to follow the GMC guidance.

'31. You must listen to patients, take account of their views, and respond honestly to their questions.'

42. The Practice has provided no evidence that they have fulfilled this requirement.

'55. You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

1 a. put matters right (if that is possible)

2 b. offer an apology

3 c. explain fully and promptly what has happened and the likely short-term and long-term effects.'

43. From the information provided the Practice do not appear to have taken the chance to fulfil this duty.

'61. You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.'

44. The Practice have not attempted to answer this complaint. In fact they look to have tried a number of options which give the very strong appearance of attempts to obfuscate the primary aim of the complaint. This was to see if the Practice had acted reasonably in the diagnosis and management of Mr A's kidney problem. This serious issue remains unanswered. This is entirely unreasonable and unsatisfactory.

'65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

45. It is my opinion that the behaviour of the Practice in relation to this complaint is such that it threatens the reputation and trust the public put in their doctors. This is a serious matter and one which the GMC may wish to comment on.

'73. You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.'

46. The Practice has not followed this guidance.

47. In conclusion, the Adviser said that, in his opinion, the Practice had deliberately complicated the issues around Mr A's complaint with the aim of not answering it which had been compounded by the poor systems they had in place. The Adviser said the Practice had failed to engage with the Board to allow mediation and assistance to improve their situation which led to the injustice of Mr A not having his complaint answered.

48. Finally, the Adviser commented that the actions, and lack of action, taken by the Practice were serious enough to threaten the reputation of the medical profession because they had repeatedly failed in the duties expected of them by the GMC.

Decision

49. Having reviewed all of the evidence available in this case, I uphold the complaint.

50. The evidence available indicates that the Practice failed to handle Ms C's complaint appropriately in line with *Can I help you?*. In addition, I have extreme concerns about the Practice's resistance to accept that they failed to handle the complaint properly. Their refusal to comply with my recommendations has resulted in my office having to issue this report when the complaint should have been finalised following the decision issued by my complaints reviewer.

51. In light of my findings I have made the following recommendations.

Recommendations

52. I recommend that the Practice:	*Completion date*
(i) acknowledge acceptance of Mr A's complaint and answer it appropriately within 20 working days;	23 September 2015
(ii) apologise to Mr A for failing to deal with his complaint appropriately in line with *Can I help you?*; and	23 September 2015
(iii) provide the SPSO with a copy of its complaint handling procedure to demonstrate compliance with *Can I help you?*	23 September 2015

53. We will follow-up on these recommendations. The Practice are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

54. I recommend that the Board:	*Completion date*
(i) consider referring the Practice to the GMC; and	28 October 2015
(ii) consider its position in relation to the contract held with the Practice.	28 October 2015

55. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these

recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	the aggrieved
the Practice	Mr A's medical practice
the Centre	the health centre where the Practice is based
Ms C	the complainant
the Board	Greater Glasgow and Clyde NHS Board
the Adviser	a clinical adviser who is a general practitioner
the Chief Executive	the chief executive of the Board
CHP	Community Health Partnership – a subdivision of the health board with responsibility for delivery of primary care services, promoting health improvement and working with social services to provide social care
GMC	General Medical Council

Annex 2

List of legislation and policies considered

Patient Rights (Scotland) Act 2011

Can I Help You?

Good Medical Practice 2013